NEWSLETTER

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AGING HEALTH WORKFORCE – AGING PATIENTS: MULTIPLE CHALLENGES FOR HOSPITALS IN EUROPE

11-13 JUNE 2012 – BERLIN (DE)

Since 1981, HOPE organises an exchange programme for professionals with managerial responsibilities working in hospitals and healthcare facilities. The aim of the HOPE Exchange Programme is to promote a better understanding of the functioning of hospitals and healthcare services within the European Union and its neighbour countries. It facilitates co-operation and exchange of best practices.

The HOPE Exchange Programme is not a medical or technical programme: it is a practical and multi professional management programme. Doctors, nurses, but also economists, lawyers with managerial background are welcome to join the programme. A wide range of host institutions, in the private and public sector, participate by sending and/or receiving participants. Every year, hundreds of professionals contribute to the success of the programme. Since its creation, several thousands of professionals have benefited from the HOPE Exchange Programme.

Each year, the HOPE Exchange Programme is focused on a different topic. This time, in line with the European Year of Active Ageing and the European Innovation Partnership on Healthy Ageing, the subject is "Ageing workforce - ageing patients: multiple challenges for hospitals in Europe". Participants will have the opportunity to investigate how this topic is managed in their host country. At the end of the training, all participants are invited to share their results in the Berlin HOPE Agora (11 -13 June 2012) with a HOSPAGE Open-to-all Conference to take place on 12 June 2012.

Aging health workforce – aging patients: multiple challenges for hospitals in Europe

HOSPAGE

FROM 11 TO 13 JUNE 2012 IN BERLIN, GERMANY
The European symposium on "Aging health workforce – aging patients"
Featuring the AGORA of HOPE Exchange Programme 2012

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www.hospage.eu

LAST DAYS TO REGISTER

Public Health

EU HEALTH POLICY FORUM

On 10 May 2012, HOPE attended in Brussels the EU Health Policy Forum, the gathering of European stakeholders of the healthcare and public health sector.

The Forum started with updates by the Commission on activities from the European Innovation Partnership in Active and Healthy Ageing and on the work of the Council working Group on Public Health at Senior Level (SLWP).

The Commission reminded the audience of the aims and functioning of the Partnership for Active and Healthy Ageing, emphasizing its six concrete actions and its commitment to delivering results, providing the necessary framework for action and acting as a channel for initiative.

A representative from the Danish Presidency highlighted the importance of collaborating with stakeholders and presented updates of the SLWP's current activities, including its reflection process on innovative approaches for chronic diseases and its work on modern, responsive and sustainable healthcare. A representative from the upcoming Cyprus Presidency also mentioned the areas it was going to place focus on, such as the revision of the Medical devices Directive or other non-legislative dossiers, such as the mid-term evaluation on organ donation and transplantation or the report on the social determinants of health inequalities.

The forum was also an opportunity for the Commission, in the person of Paola Testori Coggi, Director of the Directorate-General for Health and Consumer Affairs, to give an update on its key developments in EU health actions. Amongst other things, Mrs Testori Coggi talked about the recently adopted Communication "Towards a job-rich Recovery", as well as the Health for Growth Programme 2012-2020 and the importance of seeing health as a contributor to growth and not as a cost.

Another issues addressed during the Forum was the revision of the clinical trials Directive. The Directive regulating clinical trials was adopted in 2001 but was highly criticized from the start; for the administrative burden, it brought on authorization procedures. This acknowledgement, as well as the strong decline in the number of medical trials in Europe, pushed the European Commission to launch a revision of the Directive aiming at harmonizing procedures and ethical standards, fostering collaboration between countries and facilitating international trials.

The Commission insisted on the fact that the revised Directive would not change the existing rules, which do not allow pre-marketing authorization for medical devices. It also gave more information on what the Directive would focus on in priority:

- encouraging the submission and assessment of multinational trials and increased collaboration between Member States on clinical trials;
- introducing adaptation to the risk: currently, the same rules apply for all trials. The Commission wants to introduce a "risk" dimension, differentiate the rules according to the risk-potential of the medicine and clinical trial;
- taking into account the global aspect of clinical trial and encourage collaboration between countries. The Commission suggests establishing a list of all ongoing clinical trials as well as possibilities of inspection.

Short updates on other current EU Policy dossiers (Health Technology Assessment, Health Workforce, Heidi) were also given by the Commission, as well as a follow-up on the Secretariat and the Commission's work on chronic diseases and an update on the measles situation in Europe.

More information:
http://ec.europa.eu/health/interest_groups/eu_health_forum/policy_forum/index_en.htm

MEPS BACKS UP PROPOSAL ON INCREASED PHARMACOVIGILANCE

On 8 May 2012, Members of the European Parliament in the Public Health Committee backed a draft proposal aiming at modifying existing legislation on pharmacovigilance and establishing an automatic EU safety evaluation in the event of a safety alert about a medicinal product in any EU Member State. An update on EU pharmacovigilance rules was decided in 2010 and is set to take effect in July 2012. However, following the Médiator case, these rules were subject to "stress tests", revealing gaps that still needed to be addressed.

This acknowledgment led to the current proposal, which would introduce an emergency procedure to be triggered automatically if, for example, a Member State were to withdraw a medicinal product from the market or if a company decided not to renew a marketing authorization for safety reasons.
In its 2010 proposal, the Commission had already proposed to make this procedure automatic, but this requirement was dropped by the Council. After adopting the two reports by Linda McAvan (S&D, UK), MEPs also inserted amendments aiming at clarifying the procedure and improve transparency, notably transparency requirements on companies. Finally, if this proposal were to be adopted by the Council, the European Medicines Agency would have to put in place a system that would ensure that all new medicines and medicines on which regulators have ongoing safety concerns are labelled with a black symbol, in order to enable patients and healthcare professionals to identify them.

The Rapporteur is currently working on a first reading agreement with the Council. The plenary vote should take place during the 2-5 July 2012 session in Strasbourg.

More information:
http://ec.europa.eu/health/humanuse/pharmacovigilance/developments/index_en.htm

HEALTH WORKFORCE - COMMISSION'S WORKING GROUP

The working group on Health Workforce was meeting on 10 May 2012 for a presentation of the Action Plan for the EU health workforce adopted as part of the Commission Communication "Towards a job rich recovery" (COM 173/2012 of 18 April 2012) as well as for an update on the on-going actions at EU level related to health workforce.

On workforce planning and forecasting the baseline analysis of the feasibility study on *Forecasting health workforce needs* was presented by Matrix, the company that won the tender of the Commission. The Joint action on health workforce planning and forecasting was then presented by the Belgian Health Ministry, followed by a presentation of the work of the OECD on workforce planning.

Four other initiatives were presented around skills needs in the healthcare sector: the skills council in the area of nursing and care, the Pilot network of nurse educators and regulators, the sector skills alliances and the European skills/competences, qualifications and occupations.

Sector skills Alliances (competence of Directorate general Education) are intended to address current and future skills needs by developing training supply at European level. The Alliances are designed to improve the responsiveness of vocational education and training to labour market needs, while promoting innovation and transfer of good practice.

The next call for proposals offers 400 000 EUR co-financing (75%) to set up a pilot sector skills alliance in the health and social sector (as one of five sectors). The deadline is on 16 August 2012: http://ec.europa.eu/education/calls/s0112_en.htm

European skills/competences, qualifications and occupations (ESCO) is calling for experts on the Reference Group on health and social sector. The objective of ESCO (competence of DG Employment) is to create a multilingual easy to use terminology of skills/competences, qualifications and occupations.

This European classification tool will help support job searches across the EU as advertised on the European Job Vacancy Monitor http://ec.europa.eu/eures/home.jsp?lang=en

ESCO is being developed in consultation with stakeholders and experts. The Commission's DG for Employment has launched a call for experts to participate in the reference group health and social sector. The first reference group meeting will take place on 3 July 2012:
http://prezi.com/hqhnkuqzxhtc/working-group-on-health-workforce-esco/

eHEALTH TASK FORCE - BETTER USE OF HEALTH DATA TO IMPROVE HEALTHCARE

On 7 May 2012, the eHealth Task Force, a high-level expert group on eHealth, stressed the necessity for the European Union to reach an agreement on how to use healthcare data if it wished Information and Communications Technologies (ICT) to fulfil its potential of enabling more affordable, less intrusive and more personalized healthcare. This is one of the five key recommendations delivered by the group, headed by Toomas Hendrik Ilves, the President of Estonia, for redesigning health in Europe to Vice President Neelie Kroes and Commissioner Dalli at eHealth week 2012 in Copenhagen, Denmark.

The eHealth Task Force was established a year ago, in order to advise the European Commission on how to allow eHealth to play its role as an enabler of safer, better and more efficient healthcare in Europe. The Task Force presented its report during the "Smart Health- Better Lives" conference in Copenhagen. The conference, co-organised by the Danish Presidency and the Council, gathered health ministers, government officials and stakeholders to promote innovation for smart health.

On this occasion, the Task Force presented the following five key recommendations to the Commission.

- To create a legal framework and space to manage the massive amounts of health-related data. This implies the implementation of safeguards in order for citizens to use health applications with the confidence that their data will be handled appropriately. This recommendation aims to boost the integration of user-generated data with official medical data, leading to healthcare that is more integrated and personalised.
- To support health literacy and ensure that health data is available in a form that patients can understand.
- To create a 'beacon group' of Member States and regions committed to open data and eHealth, including pioneers in eHealth applications.
- To use data power: eHealth applications must prove worthy of users' trust. Only then will users make their data available for feedback on preventive care or for benchmarking and monitoring performance of health systems.
- To re-orient EU funding and policies – ensure the responsiveness of specific eHealth budget lines and enable the development of good ideas into fast prototyping and testing. Transparency should also be required from health institutions through procurement and funding criteria.

These five recommendations will feed into eHealth-related EU initiatives, including the eHealth Network, which is being established according to the provisions of the Directive on patients' rights in cross border healthcare. In the second half of 2012, the Commission will present the eHealth Action Plan 2012-2020 to scale-up eHealth for empowerment, efficiency and innovation.

More information:
http://ec.europa.eu/information_society/activities/health/policy/ehtask_force

eHEALTH STAKEHOLDER GROUP MEETING

The eHealth Stakeholder Group was meeting on 7 May 2012 in Copenhagen. HOPE is member of the group.

For this second meeting, members were provided updates on the Commission work in four key areas of cooperation:

- staff Working Paper on Telemedicine;
- patient access to health records;
- telemedicine deployment;
- interoperability.

All four areas remain in their first stages of development.

The European Commission provided an update on activities related to interoperability, benchmarking and the upcoming eHealth Action Plan.

eHEALTH - EU/US WORKSHOP

DiG INFSO and U.S. Department of Health and Human Services & ePractice.eu organised a workshop on 7 May 2012 in Copenhagen. The objective of the workshop was to present and discuss current and future perspectives of EU and US cooperation on eHealth matters. The workshop provided an opportunity to review on-going collaborations, including those developed in the context of the Memorandum of Understanding (MoU) on cooperation surrounding health information and communication technologies.

Most notable amongst this work is the jointly developed EC-HHS roadmap for the development of internationally recognised interoperability standards and interoperability implementation specifications for electronic health information systems.

Other mutual priorities currently the subject of active cooperation include cooperation around strategies for development of professional workforces with the health IT skills to realize the inherent promise of health ICTs to support better, more affordable and accessible healthcare as well as healthier ageing workforces, were the centre of discussion.

The MoU was signed in Washington on 17 December 2010 by the European Commission Vice-President Neelie Kroes and Kathleen Sebelius, the US Secretary of Health and Human Services.

The implementation of the EU-US MoU on health ICT issues, EU-US perspectives on encouraging health ICT innovation, and the international dimensions of eHealth will also be presented by high-level speakers from the EU and US administrations and other international bodies including the World Health Organisation (WHO) as well as the health-care private sector.

More information:
http://www.epractice.eu/en/events/ehealthweek-eu-us-cooperation

ACCESS TO MEDICINE - BIOSIMILARS

Part of the initiative of the Commission (DG Entreprise) on access to Medicines in Europe, the Project group on Biosimilars was meeting on 18 April 2012 in Copenhagen.

In this fourth face-to-face meeting, the biosimilars working group welcomed Dr. Christian Schneider, the Chair of the EMA Biosimilar Medicinal Products Working Party. Dr. Schneider shared with the Group an introductory note on the science underlying the approval of biosimilars.

Concerning work area B (Identification of the full therapeutic area) Caroline Dunn, IMS, presented the data on "Biosimilar accessible market: Size and biosimilar penetration". This market study is one of the finalized deliverables of the working group.

Thereafter, EGA presented the still immature results of the survey on "Good practices and obstacles related to the uptake of biosimilars". The group agreed that Member States which have not contributed yet, will be reminded via competent authorities (P&R Network) or the Transparency Committee, alternatively setting up phone interviews if re-circulation of the questionnaire does not provide sufficient response.

In the work areas focusing on target group related information, the paper that is currently in a drafting phase was presented to the group (by the coordinator of the drafting subgroup, EGA). The work on the information paper is in good progress, but further process and deadlines had to be agreed on. The group asked the drafting subgroup to set up a project plan with the next steps and deadlines. The group agreed that in the Q&A part of the information paper the max. number of questions per target group should not exceed 20.

The goal is to finalise the outstanding deliverables (mainly the paper on information about biosimilars) by October 2012. The final deliverables should be presented at the next Steering Group meeting in November. The next face-to-face meeting will take place on 11 September 2012 in Brussels.

STATE AID - COMMISSION MODERNISES CONTROL RULES

Competition Commissioner Joaquin Almunia unveiled, on 8 May 2012, his plans to tackle a reform of state aid control. A communication adopted by the College of Commissioners outlines the aims of the modernisation the Commission plans to put into place.

The primary objective of modernising state aid control consists in strengthening growth by facilitating the treatment of aid which is well designed, targeted at identified market failures and objectives of common interest, and least distortive. The aim is to guarantee that public aid stimulates innovation, the use of green' technologies and the development of human capital. State aid control already supports such growth strategies.

The second objective of this reform is to focus state aid control more on cases with the biggest impact on the internal market. This entails closer scrutiny of large aid packages that might lead to distortions of competition and enquiries by sector across Member States.

The objective is also to simplify and clarify procedures that have become increasingly complex over the years, in order to improve consistency and streamline aid assessment. The Commission will first clarify and spell out more precisely the concept of state aid in the light of other key concepts and Court of Justice case law. It will then revise its state aid procedural regulation to set priorities for complaint handling in order to prioritise cases having a potentially major impact on competition and trade in the single market and will increase the means available for such priority enquiries.

The revision of the procedural regulation and the Council entitling regulation will be ready next autumn. The other texts will be revised in 2013 and the package should be finalised by December 2013.

ENERGY EFFICIENCY - POSSIBLE AGREEMENT ON DIRECTIVE IN JUNE 2012

Addressing the press on 8 May 2012, the day following the trilogues between the three major EU institutions, shadow Rapporteur Britta Thomsen (S&D, Denmark) said she was confident that an agreement could be reached by the Council and the European Parliament on the issue of the Energy Efficiency Directive by June, with a plenary agreement in July.

The Commission presented its proposal almost a year ago, in June 2011 and the vote at the European Parliament's energy committee on the report by Luxembourg Green, Claude Turmes, took place at the end of last February. Although the issue of binding objectives remains the major subject of disagreement between the Council and the Parliament, Member States are slowly and slowly becoming aware that clearly defined binding targets on energy would allow them greater flexibility than binding measures.

Under the new measures that had been proposed by the energy committee, Member States would need to start renovating 2,5% of the total surface area of their public buildings when the total utilised surface area is over 250 m² by January 2014. One of the points currently being discussed revolves around the will, expressed by Member States, to reduce public building renovation requirements so that they apply exclusively to government findings.

More information:
http://ec.europa.eu/energy/efficiency/eed/eed_en.htm

INTEGRATED HOMECARE - LOOKING FOR PARTNERS

HOPE is looking for hospitals to join a project of Comparative effectiveness research in integrated homecare.

On 10 July 2012, the next FP7-Call will be published with deadline 2 October 2012. It will contain in a line HEALTH.2013.3.1-1: Comparative effectiveness research (CER) in health systems and health services interventions.

CER is a new approach to research in applied health care established as part of the Obama health care reform in the USA. As the field is new, there are so far very few results. CER differs from traditional health economic cost-effectiveness analysis (CEA) in that the main focus is on outcomes with often simplified cost calculations by a few activity-based cost units (ABC-costing).

Integrated care is explicit as a field of priority for CER. In 2012, a health technology assessment (HTA) of integrated homecare (IHC) has been published by the FP7-Homecare 222954, see HOPE Newsletter, April 2012 (website: www.integratedhomecare.eu).

The core of the approach is to select 12-15 European hospitals across Member States, which would commit themselves to implement the full Homecare-package for stroke, COPD and heart failure in pilot-projects with at least 75 intervention patients for each condition in each hospital region. The focus is on hospitals with 400-700 beds serving a local region of at least 200,000 inhabitants. Participating hospital would commit to monitor their results by the benchmarking system presented in the 'HTA of IHC in EU' from Homecare1 in order to compare their baseline with the pilot-results and their pilot-results with best international practice. Hospital should have specialized service in all of the three selected conditions.

The selected hospitals will be compensated for their costs of intervention according to the number of patients completing the IHC-programme and a fee-per-patient in accordance with the Dutch trials on bundle-payment and the intervention costs calculated in the 'HTA of IHC'. This may amount to a budgeted grant of 150-200,000€ per hospital.

Hospitals, which may be interested to join the CER-project, are asked to contact HOPE no later than 15 June 2012:
sg@hope.be

HIGH LEVEL CONFERENCE- EU HEALTH PROGRAMMES: RESULTS AND PERSPECTIVES

On 3 May 2012, HOPE attended the Commission's high Level Conference on EU health programmes, entitled "*EU Health Programmes: results and perspectives*".

The conference, which marked the 10-year anniversary of the Health Programmes, focused on the results, achievements and lessons learnt of the last and current Health Programmes, and on future perspective for the next Health Programme, which will begin in 2014 and end in 2020. It included plenary sessions and panel discussions, as well as four parallel workshops.

The very first health Programme, which covered the period 2003-2008, was allocated a budget of €312 million. Before this first programme, 8 health actions ran in parallel from 1998 to 2002.

The second Programme "Together for Health, which is the current health Programme (2008-2013) was allocated €321,5 million and focused on reducing health inequalities and creating more synergies of Health with other EU programmes and policies. Between 2003 and 2012, the second health programme financed 673 actions that addressed issues related to the fields of health information, health promotion and health security. In terms of financial mechanisms, for the 2003-2011 period, the programme allocated 466 grants for projects, 274 tenders, 18 direct grant agreements with international organisations, 16 Joint Actions with Member States, 43 operating grants and 43 grants for conferences.

Three external evaluations were conducted on the current health Programme. These evaluations highlighted the importance of focusing on specific objectives and prioritizing actions that are necessary to obtain measurable results. In addition, emphasis was put on the need to promote wider EU participation and of increasing the visibility of the Programmes in order to enhance the visibility of results. Acknowledging the key role of dissemination, the evaluators also put forward the need to develop more detailed dissemination strategies and for members of DG SANCO, the Executive Agency and national committee members to play a more active role in disseminating results. Finally, the evaluators put emphasis on collecting comparable data, networking, training, setting up educational material and guidance and identifying and validating best practices.

Martin Seychell, Deputy Director-General of the Directorate-General for Health and Consumers, reminded the audience of the challenges awaiting the upcoming Health for Growth Programme. With a budget of € 446 million, the Programme will have to face issues related to the changing demographic context and budgetary constraints resulting from the financial and economical crisis. The Programme will also have to address issues such as the control and prevention of chronic diseases, pandemics, the emergence of cross-border health-threats and the need to improve the cost-effectiveness and sustainability of health systems.

John Dalli, Commissioner for Health and Consumer Policy, who opened the event, emphasized the fact that in times of financial and economic crisis, considering the limited available resources, it is crucial to identify which activities will bring the most added value. For Mr. Dalli, Health investment is a driver for growth and it is time more than ever to shape a social Europe and make health a priority.

More information:
http://ec.europa.eu/health/programme/events/ev_20120503_en.htm

HIT SWEDEN - WHO PUBLICATION

The WHO European Observatory on Health Systems and Policies has published the new profile of the Swedish health system, part of the series "Health Systems in Transition" (HiTs). The new report was officially launched on 10 May in Stockholm at meetings hosted by the Ministry of Health and the Swedish Association of Local Authorities and Regions.

The Health Systems in Transition (HiT) profiles are reports that provide a detailed description of a health system, reforms and policy initiatives under development in a specific country, providing relevant information to support policy-makers and analysts in the development of health systems in Europe and facilitating the exchange of experiences of reform strategies in different countries. They are based on a periodically revised template in order to facilitate comparisons between countries.

The new HiT on Sweden provides key information on all aspects of the health care system. Reforms that started in the 1990s have gradually diversified the spectrum and introduced new forms of governance, also aiming to extend the level of choice and responsiveness towards patients. Despite the fact that health outcomes and clinical quality in Sweden may be among the best in the world, much focus has been put in recent years on increasing regional transparency and improving the safety, quality and efficiency of services. The further development of primary and elderly care as well as a better coordination between providers have been priorities for policy makers.

Three basic principles apply to health care in Sweden: human dignity, need and solidarity, and cost–effectiveness. The Ministry of Health and Social Affairs is responsible for overall health care policy. County councils/regions and municipalities are responsible for the organisation of health services and are represented by the Swedish Association of Local Authorities and Regions (SALAR). The municipalities are legally obliged to meet the care and housing needs of older people and people with disabilities.

Both the county councils and the municipalities levy proportional income taxes on the population to cover the services that they provide. They also generate income through state grants and user charges. The government regulates high-cost protection schemes that cover health care outpatient visits. A national ceiling for out-of-pocket payments and for co-payments for prescribed drugs is established at central level; they are uniform throughout the country and fully regulated by the government.

There is a mix of publicly and privately owned health care facilities, but all of them are generally publicly funded. Primary care forms the foundation of the health care system. Services for conditions requiring hospital treatment are provided at county and regional hospitals. Highly specialized care, requiring the most advanced technical equipment, is concentrated in regional hospitals.

One important aim behind structural changes in Swedish health care since the 1990s has been a shift from hospital inpatient care towards outpatient care at hospitals and primary care facilities. Moreover, since 2005, there is a care guarantee, which strengthens the patient's position. It is based on instant contact (zero delay) with the health care system for consultation; seeing a general practitioner (GP) within seven days; consulting a specialist within 90 days; and waiting for no more than 90 days after being diagnosed to receive treatment. From July 2010, this is regulated by law and includes all elective care in county councils.

During the past 10 years, county councils have focused on developing primary care and coordinated care for older people. The number of private primary care providers has increased substantially and in parallel the restructuring of the hospital sector, involving specialization and concentration of services has continued from the 1990s. The governance and management of services have increasingly come to focus on comparisons of quality and efficiency.

Recent initiatives are guided by an emerging performance paradigm in the governance and management of health care. More attention is being paid to the need to establish valid performance indicators and to increase abilities to monitor performance on a regular basis by investments in registers and new information technology (IT) solutions. As a result of increased transparency, more attention is also directed towards differences in results and outcomes across regions and providers, and the learning opportunities that such differences provide.

An emerging issue is the long-run financing of health care services. The prognosis shows increased demand because of rapid changes with more older people over the next 10 to 15 years. There is no political support for any major changes in the financing of health care.

Available at:
http://www.euro.who.int/__data/assets/pdf_file/0008/164096/e96455.pdf

HIT POLAND - WHO PUBLICATION

The WHO European Observatory on Health Systems and Policies has published the new profile of the Polish health system, part of the series "Health Systems in Transition" (HiTs).

The Health Systems in Transition (HiT) profiles are reports that provide a detailed description of a health system, reforms and policy initiatives under development in a specific country, providing relevant information to support policy-makers and analysts in the development of health systems in Europe and facilitating the exchange of experiences of reform strategies in different countries. They are based on a periodically revised template in order to facilitate comparisons between countries.

In Poland, the Semashko model has been progressively replaced with a decentralized system of mandatory health insurance complemented with financing from state and territorial self-government budgets. The main challenges are linked to the reinforcement of primary care and to the adoption of new payment mechanisms such as diagnosis-related groups (DRGs), which have been introduced in recent years but need to be expanded to other areas and intensified. Limited financing seems to be

the biggest barrier in achieving accessible and good quality of health care services and in improving patient satisfaction.

The Ministry of Health is the key policy-maker and regulator in the system and is supported by a number of advisory bodies. Compulsory health insurance covers 98% of the population and guarantees access to a broad range of health services. Health insurance contributions, borne entirely by employees, are collected by intermediary institutions and are pooled by the National Health Fund (NFZ) and distributed between the 16 regional NFZ branches. Up to 86% of contributions paid in a given year can be deducted directly from tax contributions. The limited financial resources of the NFZ mean that broad entitlements guaranteed on paper are not always available. The high share of private expenditure is mostly represented by out-of-pocket (OOP) payments, mainly in the form of co-payments and informal payments. Informal payments are widespread but their extent has been decreasing following substantial anticorruption measures.

The NFZ is the sole payer in the system, charged with contracting health services with public and non-public providers. All health care providers meeting certain criteria may compete for contracts with the NFZ. With the exception of primary care services and purchasing of medical devices, contracts can be awarded by means of competitive tenders or (rarely) negotiations. How much providers are actually paid ultimately hence depends on the bids submitted to the NFZ.

Primary care is financed by capitation, and the fee-for-service principle applies for secondary outpatient care, dental care and certain public health programmes. The state budget covers contributions for vulnerable groups. Since 2008, a DRG-like system has been in place for inpatient care and was extended to certain specialized outpatient services in 2011. Most emergency services are financed on a per diem basis from the state budget.

The majority of hospital beds are public, but the number of non-public hospitals has been rising in the past decade partially because of the transformation of public hospitals into Commercial Code companies. Private hospitals are generally newer and more financially stable than the public ones; their facilities are in general in better conditions, so maintenance is less costly. Moreover, the most advanced procedures and materials are only available in the private sector. Ambulatory care provision is mostly private. Territorial self-governments are the principal source of investment funding for hospitals. Funding from the state budget is also significant and is mainly allocated to the implementation of projects co-financed by the EU.

A primary care physician is usually the entry point to the health care system, steering patients to more complex care. A referral is needed to access specialist medical care, with the exceptions of certain specialists and certain conditions. At each level of care, patients have the right to choose among contracted providers. Single-specialty hospitals are rare. Day care is not well developed and some less-serious cases could well be treated in outpatient settings. Poland has a long tradition in health resort treatment, which is offered in health resort hospitals and sanatoria. Rehabilitation and long-term care are provided within both the health care sector and the social care sector, but the coordination between the two could be improved.

In the last ten years, major reforms and policy initiatives in healthcare aimed at improving access, information system, organisation and financing in the hospital sector, fighting corruption, strengthening patient rights, improving reimbursement of providers by the NFZ (introduction of

DRGs in various areas of care), addressing the shortage and outward migration of professionals and improving quality of care. Limited financing seems to be the greatest barrier in achieving accessibility, good quality of health care services and patient satisfaction. VHI has been often proposed as a source of additional financing but, despite the substantial share of private health expenditure, all initiatives in this area have so far failed. Privatizing public hospitals as a solution to inefficient management and accumulated debt has been strongly opposed and politicized, but privatization of health care institutions has been taking place and the 2011 Law on Therapeutic Activity encourages territorial self-governments to commercialize hospitals.

Substantial measures have been undertaken in the area of quality control, including health technology assessment (HTA) and the introduction of accreditation standards for hospitals and primary care, but such initiatives are still lacking in many areas of care. The increasing shortage of health care personnel also endangers service provision and may require complementing the ad hoc interventions practised so far by a more strategic approach.

Limited resources, a general aversion to cost-sharing stemming from a long experience with broad public coverage and shortages in health workforce need to be addressed before better outcomes can be achieved by the system. Increased cooperation between various bodies within the health and social care sectors would also contribute in this direction.

Available at:
http://www.euro.who.int/__data/assets/pdf_file/0018/163053/e96443.pdf

HIT VENETO REGION, ITALY - WHO PUBLICATION

The WHO European Observatory on Health Systems and Policies has included in the series of "Health Systems in Transition" (HiTs) one of its members, the Italian region of Veneto, whose profile has just been published. This new report illustrates the important role that regional authorities play in certain decentralised health systems.

The Health Systems in Transition (HiT) profiles are reports that provide a detailed description of a health system, reforms and policy initiatives under development in a specific country, providing relevant information to support policy-makers and analysts in the development of health systems in Europe and facilitating the exchange of experiences of reform strategies in different countries. They are based on a periodically revised template in order to facilitate comparisons between countries.

The Veneto Region is one of Italy's richest regions and the health of its resident population compares favourably with other regions in Italy. The publication explores the health system of this region and some of the challenges that local and regional administration, together with the national ones, currently faces, such as an ageing population, the incidence of chronic diseases, as well as the ever-present problem of keeping the regional health budget balanced.

Under Italy's National Health Service the organisation and provision of health care is a regional responsibility. Like other regions, the Veneto Region is linked to the national government via the

Standing Conference of the State and the Regions and Autonomous Provinces (Conferenza Stato-Regioni).

Objectives for the health system are established by the Regional Health and Social Care Plan, which also reflects the priorities and requirements laid out in the National Health Plan, and the agreements reached at the State-Regions Conference. In addition, a Regional Development Plan (Piano Regionale di Sviluppo) coordinates policies with other relevant departments such as environment and urban planning.

Regulation of the health system is divided among different organisations, for example those that govern the accreditation of facilities, the registration of health professionals and the regulation of the use of medicines and medical devices. Joint efforts are underway to improve information systems, and the Veneto Region is one of the few Italian regions that has established a unit for health technology assessment (HTA).

The SSN covers the whole population and regions must provide a nationally defined (with regional input) basic level of care (i.e. a health benefit package) to all of their residents. Extra services may be provided if budgets allow. The nationally set allocation guidelines stipulate that 5% of a region's National Health Fund funding should go to public health, 44% to hospital care and 51% to district-level (primary) care. Statutory user charges applied to secondary care and outpatient prescription drugs account for 2-3% of total spending on health care. Most private spending is through direct payments for privately provided health care. Supplementary voluntary health insurance has only recently been introduced and does not play a major role in the Veneto Region or in Italy as a whole.

In the last few years, the Veneto Region has reviewed the organisation of facilities in order to meet the need for fewer hospitals and more primary and community care. There has been an ongoing process to turn small hospitals into post-acute care and community health facilities. Hospital beds are not evenly distributed across the region and further rationalization will be required in some areas. Standard medical equipment is purchased at the discretion of individual Local Health And Social Care Units (ULSS), while expensive items need authorization from the regional decisional committee (Giunta).

Health care is provided by 21 local health and social authorities (ULSSs), 2 hospital enterprises (aziende ospedaliere (AOs)), 2 hospitals in the national hospitals for scientific research (istituti di ricovero e cura a carattere scientifico (IRCSS)) scheme and private accredited providers, all of which deliver services across three broad programme areas: public (preventive) health care, district-level primary and community care, and hospital care.

Access to primary care does not differ from the framework established nationally as general practitioners (GPs) and paediatricians deliver primary care; ambulatory (outpatient) services are provided by public and private accredited facilities (with a co-payment). Patients who wish to use ambulatory services exclusively in the private sector incur the full cost of care. Acute hospital care in the national health system (SSN) is delivered by public and private accredited facilities. Currently, the hospital sector is being restructured, with the conversion, merger or closure of smaller hospitals, in order to deliver services more efficiently and to improve the response to population needs.

The 2009 Law on Fiscal Federalism (Law No. 42) outlined important innovations for health care financing. Future developments will focus on the implementation of the annual Pacts for Health between the central government and the regions and the adaptation of services to meet new health system challenges, particular those associated with the ageing population, the incidence of chronic diseases and the ever-present problem of keeping the regional health budget balanced.

Available at:
http://www.euro.who.int/__data/assets/pdf_file/0007/162583/e96452.pdf

EUROHEALTH - WHO PUBLICATION

The edition number 1, volume 18 of EuroHealth has been published by the WHO European Observatory on Health Systems and Policy. The three sections of the publication debate the effects of the financial crisis, with examples from Ireland, Greece, Estonia and Czech Republic; illustrate the patients' perspective on the Professional Qualifications Directive; discuss obesity in Spain, Danish performance on chronic care, Dutch health insurance system and pharmaceutical market reforms in Portugal.

In the first section, the first article summarises the results of a WHO study on how European countries have responded to budgetary pressures in the context of the global economic crisis. It illustrates the variety of health policy responses from the European governments, but it also highlights that in Greece, Ireland and Portugal, rescue packages from the "troika" (the European Commission, the International Monetary Fund and the European Central Bank) and the resulting pre-conditions for receipt of funds mean that international organisations are now directly intervening in national health policy. Regardless of who the decision makers are, ideally they should be guided by a focus on enhancing value in the health system rather than on identifying areas in which cuts might most easily be made.

Following articles focus on Ireland, Greece, Estonia and Czech Republic. In Ireland, austerity measures in the health sector aimed to contain costs, shift costs from public sector to private households and target recruitment and salaries of health sector workers. The plan of the new government (appointed in February 2011) is to establish a universal health insurance system. This is a new direction for Ireland. However, it is not a response to the current crisis although it will have gained appeal through the hardships that are being experienced and the instability in the private insurance market.

In Greece, the financial crisis has exacerbated the existing problems. A number of reforms have shaken the healthcare system tackling financial contributions to the health system, volume and quality of care and costs of publicly financed healthcare. Irrespective of their positive policy goals, these measures have started to affect public access to the health care system and to increase the financial burden on patients. Rising unemployment has led to falls in household income, resulting in patients seeking services covered by SHI rather than paying privately. In addition, unemployment negatively affects the revenues of SHI, reducing the contributions of both employers and employees.

In Estonia, cuts in the health budget and reductions in the Estonian Health Insurance Fund's (EHIF) revenues, led to some cuts in the health benefits package and in prices paid to health care providers. There are signs of economic recovery in 2011 and 2012, reflected in EHIF's increased revenues, in the restoration of health services prices paid to providers and in the inclusion in the benefit package of new services.

In Czech Republic, the economic crisis, along with more limited public resources, has provided a unique opportunity for reforms aiming to cut unsustainable expenditure growth and to make them more efficient. These reforms have been politically difficult to be implemented in the past. Prominent measure in particular included a freeze on the budget for the reimbursement of hospitals by insurance funds, the introduction of a Diagnostic-Related Groups (DRG) payment system, the decreasing number of costly acute care beds in favour of an increasing number of beds for follow-up care (and long-term care) in cooperation with the social sector. Moreover, at the structural level, a change in law has occurred to enable the merger of social health insurance funds in order to create greater economies of scale and to improve efficiency.

In the second section, an article from the International Alliance of Patients' Organizations (IAPO) completes the overview concerning the Professional Qualifications Directive (2005/36/EC), which have begun in the previous edition of EuroHealth (number 4 volume 17), where evidence of the regulator, physicians and nurses' perspective was provided. The authors highlight that the Directive must balance the need to ensure that health care professionals are able to move between Member States, ensuring that quality of care and patient safety are not compromised.

The third section of the publication examines different issues in different countries. In Spain, on 16 June 2011, the Law on Food Safety and Nutrition was passed by Parliament, containing measures related to combating child obesity and promoting healthy diets.

In Denmark, while the Chronic Care Model was introduced in 2005, the health system does not fulfil the key pre-conditions that would characterise a high-performing chronic care system. The fragmented structure of the Danish health system poses some challenges: while the primary care sector has traditionally been quite strong with the role of the GP as a gatekeeper and coordinator, patient pathways across primary/secondary care have been criticised for lack of coherence and continuity, due to the lack of appropriate communication systems among providers. The existence of different electronic health record systems across the country does not facilitate the development of full and functional electronic health record coverage within the health care sector in the near future. The value of initiatives regarding multidisciplinary teamwork within primary care, including the role of the many new municipal health centres for prevention and rehabilitation, is still uncertain, as are the effects on the quality of chronic care of improvements in communication between the different chronic care providers in primary and secondary services.

In the Netherlands, consumer mobility is an important element of the health insurance system. The idea is that consumers who are not satisfied with the premium or quality of care can switch insurer. One fifth of the population switched insurer in 2006. In 2007 – 2009, the number of switchers stabilised at around 5%. However, in 2011 the premium increased more than in previous years and consequently, the percentage of switchers increased to 8%, showing that the difference in the rate of premium is an important incentive. This is also confirmed by the motivations that people give for

switching. The results illustrate that price competition exists in the system; however, competition based on the quality of care seems to be absent.

In Portugal, the pharmaceutical market has seen permanent and intense government intervention over the last decade. The financial assistance programme given to Portugal in 2011 imposes further changes in the market. The main challenge is to achieve the targeted reduction in public pharmaceutical expenditure and to this end a variety of instruments have been implemented: international reference pricing, changes to retail and wholesale distribution margins, monitoring of prescription patterns, promotion of generics entry and price competition. While the downward adjustment in public pharmaceutical expenditure had actually begun, it is likely that the new set of measures will reinforce the trend.

Available at:
http://www.euro.who.int/__data/assets/pdf_file/0005/162959/Eurohealth_Vol-18_No-1_web.pdf

TACKLING CHRONIC DISEASE TO EXTEND HEALTHY LIFE YEARS - ECONOMIST INTELLIGENCE UNIT PUBLICATION

The Economist Intelligence Unit has just released a research, sponsored by Abbott, which focuses on tackling chronic disease as one of the chief ways of extending healthy life years in Europe.

The publication aims at contributing to the debate surrounding the EU's European Innovation Partnership on Active and Healthy Ageing and to European efforts to extend healthy life years by focusing on what can be done well before retirement to increase the odds for healthy longevity.

The focus of the publication is in particular on measures to prevent and manage chronic diseases, since these have the greatest impact on the health of older Europeans. The research considers the effects of poor co-ordination among healthcare providers, governments, civil society, private employers and the public on making the necessary changes to the healthcare system to improve the healthy longevity of both individuals and the system. It identifies best practice initiatives in prevention, early intervention and management of chronic diseases that can contribute to healthy ageing. In addition, it highlights effective ways to shift the focus from reactive, hospital-based care of the sick towards a proactive, preventive and patient-centred approach to improving health.

The Economist Intelligence Unit undertook this study in 2011. As an initial step, on November 21st 2011 a panel of experts was convened in Brussels to discuss the focus of the study. Meanwhile, extensive desk research was developed and finally subsequent in-depth interviews with 35 experts in chronic disease and healthy ageing were held. All participants in the expert panel and the interview programme are listed in the report.

Available at:
http://digitalresearch.eiu.com/extending-healthy-life-years/report

ASSESSING HEALTH-SYSTEM CAPACITY FOR CRISIS MANAGEMENT - WHO TOOLKIT

The WHO Europe has just published the Toolkit for assessing health-system capacity for crisis management.

This standardized toolkit helps countries assess the capacity of their health systems to respond to various threats and identify gaps. It breaks down the complex crisis-preparedness process into manageable units, thus enabling a ministry of health to:

- record and classify information regarding its capacity to manage crises;
- establish responsibility for specific tasks;
- determine the relationship between those involved in these tasks (partners, sectors, disciplines) with the aim of synergizing resources;
- identify shortcomings and gaps; and
- monitor progress.

It provides instructions on how to carry out an assessment; suggestions on the selection of assessment sites; recommendations on follow-up of the assessment and development of a plan of action; information about the essential attributes to identify and indicator-related questions to ask; and a list of possible sources of the information required to assess the essential attributes.

The development of this toolkit started in 2008, when the European Commission Directorate-General for Health and Consumers and the WHO Regional Office embarked on a joint project entitled, "Support to health security, preparedness planning and crises management in European Union (EU), EU accession and neighbouring (ENP) countries". This toolkit was developed and revised during the course of pilot assessments carried out in Armenia, Azerbaijan, Kazakhstan, Kyrgyzstan, Poland, the Republic of Moldova, Turkey and Ukraine. It comprises two parts a user manual and the assessment form.

Available at:
http://www.euro.who.int/en/what-we-publish/abstracts/strengthening-health-system-emergency-preparedness.-toolkit-for-assessing-health-system-capacity-for-crisis-management.-part-1.-user-manual

NON-COMMUNICABLE DISEASES IN SOUTH-EASTERN EUROPE - WHO PUBLICATION

The WHO Europe has released the publication "Non communicable diseases prevention and control in the South-eastern Europe Health Network. An analysis of intersectoral collaboration".

The greatest burden of disease, at both the global and the European levels, is attributable to non-communicable diseases. Health-promotion and disease-prevention activities aimed at reducing this burden need to involve non-health sectors and actors. This publication provides an overview of the existing tools for implementing such intersectoral action and highlights the developments in the fields of tobacco and nutrition in south-eastern Europe.

Using the concept of “best buys” – cost-effective action that accelerates results in terms of saving lives, preventing disease and avoiding heavy costs – it contains recommendations on key action to strengthen intersectoral collaboration in the prevention and control of non-communicable diseases in the future, and guidance specifically for the South-eastern Europe Health Network and Slovenia on designing and implementing joint action to this end. The proposals for action are organised in such a way as to create windows of opportunity for promoting health in all policies.

Available at:
http://www.euro.who.int/__data/assets/pdf_file/0009/164457/e96502.pdf

EUROPEAN INNOVATION PARTNERSHIP ON ACTIVE AND HEALTHY AGEING

On 3 April 2012, the European Commission held a meeting in Brussels on the European Innovation Partnership on Active and Healthy Ageing, from Plan to Action. Representatives from the European Commission, the industry, patients' associations and policy makers were among the speakers.

In this event, the "Marketplace for Innovative ideas", an interactive website designed to help those that are interested and involved in the Partnership to work together and develop their innovative ideas, was launched.

This tool is meant to help stakeholders:

- find partners to collaborate with for their initiative/project;
- find an initiative to participate in;
- provide and search for information about ageing and innovation;
- get in touch with stakeholders;
- participate in discussions in the forum;
- promote events related to active and healthy ageing.

In the opening session, Neelie Kroes, Vice President of the European Commission, pointed out this initiative will provide a network for the integrated care solutions EU countries are implementing. For him, it will be a useful tool to make contacts and share efforts.

Commissioner for Health and Consumers Affairs, John Dalli, said the Marketplace could provide with examples of cost-effective e-health solutions in EU regions and benchmarking models for others.

Laszlo Andor, Commissioner for Employment, Social Affairs and Inclusion, said the Innovation Partnership is in its implementation phase. The ambitious employment target settled by the EC by 2020 can only be achieved if citizens have good health, he said. For Andor, innovation is needed to provide care in a more efficient manner.

During the panel session about *the Strategic Implementation Plan in Action* Thomas Boerner, Senior Adviser of the Danish Ministry of Finance, stated that Partnership does not occur if someone does not create it. He underlined the importance of engagement between public and private actors as well as the need of the industry to provide with solutions. He also said it was necessary a single European market without obstacles to attract companies.

Emmanuel Faber, Executive Vice President of Danone, said that Danone was joining efforts with the European Nutrition Health Alliance. For him, innovative but simple ways to make sure people at home are screened are necessary. Harry Hendriks, Global Head of Government Affairs and CEO

Philips Benelux, said guidelines are important to step forward towards implementation. He underlined the need of commitment from political decision makers. For him, the resistance to change is the main barrier to innovation and, so, the main challenge. Anne Sophie Parent, Secretary General of AGE Platform Europe, instead said the biggest challenge is to connect with the needs of the different stakeholders and so the solution would be to connect with different actors at different levels that are interested on the issue of Active and Healthy Ageing.

The President of the Italian Medicines Agency, Sergio Peccorelli, thinks there is a need of cheap solutions now that we are living moments of constrain. For him, a partnership among health systems, GPEs, patients and industry is fundamental to produce elderly friendly solutions to medicine adherence. Nicola Bedlington, Director of the European Patients' Forum, pointed that the Partnership has to have at its core the human dimension. For him, a key indicator is to have patients' organisations in the Partnership. Bedlington said, for the Partnership to succeed, there has to be a coincidence of priorities, a creative balance, a strong leadership, good communication for people to feel engaged and a positive ground implementation. Jos B. Peeters, Managing Partner of Capricorn Venture Partners, said most solutions already exists and what is needed is technological fusion and social innovation to change the way people do things. For him, it is important to take the poorest into account both in the actions and in the budget.

After this panel session, there were three parallel sessions: on Prevention, on Integrated Care and on Independent Living and Age Friendly Cities. HOPE attended the last two.

On the Parallel Session on *Integrated Care*, good practice examples from Scotland, Northern Ireland and Basque countries were presented.

Edwin Poots, Minister of the Department of Health, Social Services and Public Safety in the Northern Ireland - after an overview of the burden of chronic diseases in Northern Ireland - explained the new model of integrated care that is being implemented, integrating the individual self-care and decisional power of the patient with good support to wellbeing, prevention and health promotion in the system.

Rafael Bengoa, Minister of Health and Consumer affairs of the Basque Government - Basque Country, Spain stressed the need of reconfigure the provider level in order to achieve the objective of better care. He highlighted the need of building the answers at a local level, closer to citizens and finally illustrated the "kronikbasque" partnership between public and private sector developed in the Basque countries. This partnership is based on four pillars: the Health business network of the Basque Country will be based on a Cluster that interacts permanently with the Basque Health Service; the R&D priorities resulting from this interaction are the key elements influencing the strategic research programs that the Department of Industry develop with the participation of companies and the RCTVI (Basque Science, Technology and Innovation Network) agents; the knowledge and Intellectual Property co-created by the Basque Health Service, the Cluster of companies and the RVCTI agents, will be well utilized. A Public-Private company will be drawn up in order to ensure a worldwide market in the form of cost-effective products and services, designed in a global logic; the innovation needs are defined to identify Innovative public procurement actions, which should provide added value to the Basque Health Service and supplying companies.

George Crooks, Clinical Director/Chief Operating Officer, NHS 24, Scotland said that education and training in telehealth and telecare and supportive self management are needed to develop adequate integrated care and a personalised answer to the needs of chronic patients, minimising the risk of admission and enhancing care in community setting and/or with day cases, but ensuring the highest level of safety and quality.

On the *Parallel Session on Independent Living and Age Friendly Cities*, Alexandre Kalache, President of the International Longevity of Brazil said a friendly city is one that has an urban environment accessible and inclusive that promotes active ageing in all of its pillars. He explained the project of Age Friendly Cities that started in Copacabana and now is worldwide. In 2007, they developed a guide to remove barriers in the cities.

Sergio Guillen, Technical coordinator of UniversAAL Project on open Platforms said the key was the development of interoperable IL solutions, including guideline for business models. Claus F. Nielsen, from the International Business Development Manager at Delta and member of the AAL Forum Program Committee, in his dynamic and creative presentation commented the need of smart ageing and the way technology can improve the life of people with health problems, including himself and his son.

The last part of the meeting, *Horizontal issues and modalities to join the Partnership*, was dedicated to explain the Partnership and the *Marketplace for Innovative Ideas*.

María Iglesia Gómez, Head of Unit Innovation for Health and Consumers, explained there are three pillars in the Partnership: Prevention, screening and diagnosis; Care and cure; and Active ageing and independent living. There are also horizontal issues such as the regulatory framework; effective funding; evidence and the Marketplace. With all this, the Partnership will focus on the following specific actions: Prescription and adherence; Management of health; Prevention; Integrated care and Interoperable solutions.

Paul Timmers, Director ICT addressing Societal Challenges of the Directorate General Information Society and Media, explained how organisations could join the Marketplace and pointed out the advantages of the e-platform.

More information at:
http://ec.europa.eu/research/innovation-union/index_en.cfm?section=active-healthy-ageing&pg=conference

INNOVATION IN HEALTHCARE WITHOUT BORDERS - EU CONFERENCE

The conference Innovation in healthcare without borders was held in Brussels on April 16 and 17 with the aim of sharing views about how, even in economic restrains, innovation is a fundamental element for increasing wellbeing of population throughout the world, with a particular focus on Africa.

“Innovation in healthcare without borders” was the third edition of the “Innovation in healthcare” cycle of conferences. HOPE has always actively supported the organisation of these events, which have the objective of acting as a policy forum for innovation in healthcare, involving key actors and policy-makers.

The two previous conferences in 2010 and 2011 provided sound contributions to the Innovation Union Communication and to the Commission proposal for Horizon 2020 respectively. The main objectives of the 2012 conference were the identification of major challenges to healthcare innovation and to build consensus to address them, the development of initiatives and opportunities for healthcare innovation and to provide continuity with previous events.

The conference was structured in two tracks: "Removing borders in the health supply chain - assessing priorities achieved to date and areas where additional effort are needed" and "Inequality and solidarity - exploring new challenges within EU and beyond". It provided the opportunity to contribute shaping the next steps forward, including the adoption of Horizon 2020 and beyond.

The conference was opened by the announcement, from Ruxandra Draghia-Akli, director of DG Research, directorate for health, of a prize of 2 million Euro for organisations and/or individuals, which would introduce change and improvements in the cold chain of vaccinations, which is at the moment the main obstacle to the spread of vaccination and prevention. The challenge will be open until 3 September 2013.

Derek Hanekom, from the Minister of Science and Technology of South Africa explained the importance of the European Innovation projects for the development of his country. South Africa is amongst the top five countries, which have beneficed from the EU FP7 programme and stressed the value of contribution to global knowledge generation through transnational Public-Private cooperation for ongoing research and promotion of innovation.

Henk Stunnenberg, representative of the academy and representative of many FP 5/6 and 7 projects, highlighted the importance of including SMEs in health consortia in view of their capacity of bridging academia and pharmaceutical industry. There are mixed experiences about involvement of SMEs, some of them very fruitful. In general, many innovative enterprises are too small and have to work with quarterly funding, which is very hard.

Other speakers discussed the issue of funding for high-risk project. Most investors are soft fund providers, they select rather than develop and funding for high risk project is lacking.

Moreover, a successful story with long-term impacts was presented regarding a small biotech company, which entered in a EU funded consortium after a good and effective ex-ante negotiation.

Now they are developing diagnostic kits and creating partnerships with other companies. Collaborative nature is one of the main stakes and main achievements of European projects.

Ruxandra Draghia analysed the invested resources in health, their outcomes and perspectives in Horizon 2020. Around 1210 project funded so far, involving 4,9 billions and 114 countries, 50% projects are ongoing. 70.000 PubMed publications and 50,000 high skilled jobs 17% envisage creating a SME while 7,4% created one or more SMEs. Nonetheless, investments in health are still characterized by high fragmentation and poor coordination and are not sufficiently funded especially if compared to the US. EU is not closing the gap with global innovation leaders (US, Asia...).

Horizon 2020 foresees 80 billion EUR budget, plus 46% increase compared to FP7 with the objectives of ensuring competitiveness, growth and jobs. The overall goal is to reach an investment of 3% of GDP in research and innovation. 8,5 billion EUR will address health, growth and wellbeing. Horizon 2020 included several new elements: simplification, inclusive approach (activities close to market), bring innovation to partners, focus on bringing business opportunities, closer to business grants in the US, renew successful partnerships.

FORUM ON HEALTH 2020 POLICY FRAMEWORK

The third meeting of the European Health Policy Forum of High-level Government Officials took place on 19 and 20 April 2012 in Brussels, Belgium. The Forum advised WHO/Europe on the final shape of the Health 2020 policy framework and three other key documents that will be submitted to the WHO Regional Committee for Europe in September 2012.

During the meeting, opened by Zsuzsanna Jakab, WHO Regional Director for Europe, and Laurette Onkelinx, Deputy Prime Minister and Minister of Social Affairs and Public Health of Belgium, representatives of Member States expressed appreciation for the Health 2020 development process and the results of the written consultation with Member States.

Participants discussed the issue of Health 2020 targets for the European Region. There was strong agreement from all Member States on six “headline” or overarching European regional targets, which will be monitored and reported on until 2020. An associated menu of indicators will be developed to monitor progress, largely based on data already collected and reported by Member States. Specific suggestions on refining the indicators and supporting monitoring systems will be addressed at an expert meeting in June 2012, with the outcome presented to the Regional Committee.

The Forum received an overview of the key findings and policy recommendations of the review of social determinants and the health divide. This included examples of interventions that address health inequalities in the European Region in areas such as early child care, education and social protection across the life-course. WHO/Europe will publish the final report on the review on its web site in June.

The participants received a preview of the upcoming European health report 2012. The Regional Committee will discuss an executive summary in September 2012, and publication of the full report is planned for December.

The current draft of the European Action Plan for Strengthening Public Health Capacities and Services was presented; it includes a revised set of 10 horizontal essential public health operations (EPHOs) as the unifying and guiding basis for European health authorities to set up, monitor and evaluate policies, strategies and actions to strengthen public health. The Action Plan also clarifies the strategic linkages between public health and health care services, particularly primary health care, as foreseen in the holistic approach to health systems articulated in the Tallinn Charter: "Health Systems for Health and Wealth". A version of the Action Plan revised on the basis of comments from Member States will be presented to the Standing Committee of the Regional Committee in May.

In addition, the participants advised on the further development of the proposed strategy and action plan for healthy ageing and considered how the Policy Forum would operate in the future.

More information at:
http://www.euro.who.int/en/who-we-are/governance/regional-committee-for-europe/news/news/2012/4/forum-finalizes-health-2020-policy-framework

INTERREG MANAGEMENT CASES - AEBR AND COMMITTEE OF REGIONS

On 20 April 2012, the seminar "INTERREG management cases" was organised by the Association of European Border Regions (AEBR) and hosted by the Committee of Regions. During the event, practicalities of INTERREG management cases were presented and main strengths and obstacles were discussed.

The first session saw the participation of Karl-Heinz Lambertz, Martín Guillermo Ramírez and Jens Gabbe, from AEBR, Walter Deffaa, Director General of DG REGIO (European Commission) and Gerhard Stahl, Secretary General of the Committee of Regions. It discussed general issues and opportunities related to the previous INTERREG programmes and, in particular, to the one under discussion.

W. Deffaa highlighted that territorial and cross-border cooperation are central for the European integration and for this reason their full potential should be exploited during the fifth INTERREG programme. He also explained the main feature of the programme under discussion and in particular the criteria of conditionality and the strengthening of economic behaviour.

The AEBR representatives despite acknowledging the climate of uncertainty around the next round of financing really appreciated the increasing of Interreg funding proposed by the Commission. K.H. Lambertz underlined that cross-border cooperation is important to strengthen the creation of Europe and that starting from now not only areas of compatibility among regions but real networks have to be put in place. G. Ramirez emphasized the role and ability of border regions to manage project and financing more effectively and shared some worries about the pre-conditions for funding required at national level, since these can easily not mirror the conditions of the regions.

In the second part of the event, many experiences of management of Interreg funds were presented and in particular obstacles and difficulties faced by managers and developers were discussed. In particular experiences of cooperation in Ireland/N Ireland, INTERREG Sweden-Norway, German

members of Euregions, Euroregion Elbe/Labe, Romania, Öresund region and many others were illustrated. Speakers and participants exchanged views about the obstacles and difficulties faced. These were mainly due to overlapping procedures, financial flows, reporting and accounting systems, beourocratic procedures and governance and coordination.

More information:
http://www.aebr.eu/en/news/news_detail.php?news_id=141

AGEING WORKFORCE - TECHNICAL SEMINAR

On the 27 April 2012, a plenary meeting of the hospital sectoral social dialogue committee was held in Brussels as a hospital sector technical seminar on "Managing the ageing workforce in the health sector: challenges, opportunities and experiences".

The seminar was aimed at facilitating and improving the discussion on the management of the ageing workforce, at better understanding the issues arising when dealing with it and at sharing expertise on possible solutions and actions at hospital level.

The keynote speech was given by Prof. James Buchan, who provided some evidence about ageing workforce, underlining the main reasons why it represents an important policy challenge: the need of guaranteeing equal opportunities (no age discrimination), the ageing workforce in the framework on an ageing population, and the importance of retaining older, more experienced and often scarce skills. He also described the pushing and retaining factors for retirement decisions and examined the elements that employers have to consider when looking at their ageing workforce. Finally, he gave an overview of the NHS pension options and of the strategies to retain professional nurses.

Two presentations, from Italy and Bulgaria, aimed at fostering the discussion about the challenge represented by an ageing workforce in these times of crisis. Elvira Gentile, from the Italian Agency for the representation of employers in the negotiations, illustrated the new reform of pensions in Italy and the parallel difficulty for recruitment of new professionals, highlighting the differences between southern and northern regions. She focused on the need of a new policy to manage the ageing of workers, incentivising their performance to maintain a good quality of services. In Italy working rules guarantee equal treatment and some degrees of flexibility to all healthcare workers, however, professional experience and seniority are fundamental for improving in the professional position. Future strategies on retention and recruitment have to go in parallel. Collective agreements already provide older workers with some advantages, but it would be useful to foresee other specific measures for them.

Slava Zlatanova, from the Bulgarian Federation of Trade Unions highlighted one of the main problems of her country: the reduction in the total number of population, the ageing population and ageing workforce and the low rate of retention of neo-graduated doctors and nurses, who leave the country for better salaries. She highlighted that ensuring a safe environment to patients means also to preserve the safety of healthcare professionals, which means to meet their needs when they start ageing. Non-discrimination policies, tolerance between generations, long-life training and flexible working time should be strengthen or introduced.

The second part of the seminar aimed at presenting good practices at hospital level, which could be adapted or replicated in different national settings. Examples came from France (FEHAP), Germany (Professional Association of Health and Welfare Services), Norway (St. Olavs Hospital – Trondheim University Hospital), Finland (Finnish Institute of occupational health), UK (Royal college of nurses) and Austria (Gespag).

In France, the rate of employment of older people is one of the lowest in the European Unon; the management of ageing workforce is then a major issue. Stimulating retention and recruitment of older persons is a matter of negotiation between trade unions and institutions. The final aim is to preserve older workers aged +55. Among the measures undertaken companies have to commit to maintain same rate of workers aged 55+, retaining or recruiting them. Companies can incur in a penalty if they do not respect these requirements. Actions must be tied to key targets and measured using indicators. Actions can include the anticipation of career development of older people for examples providing skills upgrading, improving their working conditions and preventing arduous work and situations of occupational risks and disability/inability. Moreover, the exit of older persons from the organisations must be smooth and mutually agreed.

In Norway, one of the main issues is the shortage of health personnel. The main message raising from the experience of St Olav hospital is that experienced personnel with the specific skills they have acquired throughout a long professional life, is of great importance for the hospital to achieve its goals. Hence, different actions have been put in place for healthcare professionals aged more than 55: awareness actions; development actions, in particular courses and study leaves aiming at increasing and adapting skills; and senior days off, increasing with age.

In Germany, there is a social dialogue committee for the hospital sector. Its strategy is based on conducting a demographic check, analysing needs and requirements of older professionals and implement very simple and targeted actions whenever required. Main areas and items to be analysed are: work organisation and work design, qualification and skills development, leadership and corporate culture, occupational safety and health, personnel management and recruitment.

The Finnish presentation underlined the cost effectiveness of retaining ageing workforce. Early retirement costs a lot, involving a loss of about 6% of GDP, whereas investing in health at the workplace helps reducing pensions and cutting healthcare costs. Two key dimensions differentiate how organisations deal with ageing workforce: age awareness, which implies seeing age as an opportunity, as a challenge or being neutral (equal opportunity/individual accommodations); and organisation's preparedness, which implies having a proactive or reactive attitude. Moreover, values attitudes and motivations, work community leadership, competences and health and functional capacities, together with immediate and external social environment determine professionals' work abilities. Management has to work on these elements to improve productivity, face workforce issues and promote the well-being of their older workforce.

In Austria, Gespag committed itself to implement effective measures for the active management of the challenges that lie ahead in the course of demographic changes on the staff structure and recruitment of Gespag. This is done in the form of the strategic concept of a life-phase oriented work design and layout of a working environment as well as a life phase-oriented staff development to meet the needs of employees. The process of implementation of life-stage-orientation design and staff development needs some years to develop. Main advantages are that they meet the qualitative

and quantitative personnel requirements, create an environment for job performance and career development planning, promote the personal development of employees/internal, maintain the performance and health of employees during the working life, anchoring the live phase-oriented view of corporate culture and management style, increase its attractiveness as an employer, maintain the competitiveness.

In the UK, a RCN research about the working experience of older nurses highlights that ¼ work in a lower banded job than earlier in their career. They have lower turnover but are more likely to work part-time, they are less likely to have academic qualifications. There is low confidence in adequacy of retirement income. Those in work longer have less certainly over retirement intentions, flexibility of working hours strongly correlated to job satisfaction and hence it is strongly linked to intention to work longer.

In the closing remarks the Commission, DG SANCO, highlighted the European Innovation Partnership on active and healthy ageing, the joint action on healthcare workforce. Some anticipated other actions are foreseen to face the issue of healthy ageing of professionals and to share good practices of retention and recruitment of healthcare workforce, working with the WHO to develop a common approach to this overarching issue.

IMPROVING PATIENT OUTCOMES THROUGH INTENSIVE CARE MEDICINE

With the intention of raising awareness of intensive care medicine (ICM) and its contribution to patient outcomes and health systems, the European Society of Intensive Care Medicine (ESICM), supported by the European Public Health Alliance (EPHA), organised a conference focusing on intensive care medicine's potential in regards to improving patient outcomes. HOPE attended the conference, which took place in Brussels on 15 May 2012. Intensive Care is a specialty branch of medicine concerned with the diagnosis and management of life threatening conditions requiring sophisticated organ support and invasive monitoring. It is the most expensive, technologically advanced and resource-intensive area of medical care and has a very large scope: cardiovascular, neurological, respiratory, renal, digestive etc.

MEP Dr. Cristian Silviu Buşoi (ALDE, Romania), who chaired the event, put emphasis on the importance of ensuring the quality of intensive care medicine in order to deliver the best health outcomes. According to him, intensive care medicine is a decisive care that is vital but not enough spoken about. For Prof. Richard Rhodes, President of ESICM, intensive care is about the interaction between machines and skilled medical staff and ensuring the supply of a skilled medical workforce in the field of ICM is going to be crucial in the future.

Some of the other mentioned challenges facing quality ICM and that can have a great impact on the health outcomes of ICM patients are:

- the lack of integration of care: not only are patients' conditions continually changing, but patients are often moving from one place to another while in the hospital, and enduring multiple transitions of doctors and nurses because of rotating shifts;
- the need for a better understanding of health threats (antimicrobial resistance, sepsis…);
- the need to develop a better framework for clinical trials.

The participants also discussed the issue of the existing disparities in Europe in terms of the number of available staff and beds for ICM, of invested resources and access to care.

More information: http://www.esicm.org/

OBSERVATORY VENICE SUMMER SCHOOL 2012 - 22-28 JULY 2012, VENICE (IT)

The Observatory Summer School 2012 will take place in Venice from 22 to 28 July on the topic "Performance Assessment for Health System Improvement: Uses and Abuses". As every year, it is organised by the European Observatory on Health Systems and Policies and the Veneto Region of Italy, one of its Partners.

Health systems are coming under unprecedented pressures to constrain the relentless rise in health services expenditure while simultaneously improving health outcomes, responsiveness, and financial protection. Reconciling these conflicting performance pressures is a major preoccupation for many policy makers. Their task is made more challenging by the demands for transparency and accountability and the increasing availability of comparative data, the interpretation of which is rarely straightforward.

The themes addressed during the one-week Summer School are:

- the concept of performance assessment – scope, definition and dimensions/domains;
- measuring and reporting performance – data indicators and analysis;
- implementing performance assessment in different key areas, from integrated care and financial protection to hospital and ambulatory care;
- assessing the uses and abuses of performance assessment, comparing experiences within and across countries and drawing practical policy lessons;
- integrating performance assessment within health systems governance
- enhancing performance improvements – regulatory and financial incentives, institutional mechanisms etc.

This will include reviewing innovative approaches and identifying areas and strategies to improve performance, including financial, regulatory, managerial and information mechanisms. The six-day course combines formal teaching with a highly participative approach involving participant presentations, round tables, panel discussions and group work. It draws on the latest evidence and a multidisciplinary team of experts from key organisations in the field like WHO, OECD and the EC.

The Observatory Summer School is primarily aimed at senior to mid-level policy-makers, with some junior professionals. Summer School 2012 is specifically targeted to:

- National and regional health policy-makers who wish to increase their understanding of health system performance and its implications for policy.
- Professionals working in the health sector whose responsibilities address performance assessment and improving health system performance at both a policy and implementation level.

More information:
http://www.observatorysummerschool.org/

PHARMACEUTICALS - INTERFACE MANAGEMENT COURSE

Following the PHIS (Pharmaceutical Health Information System) project on Hospital Pharmacy, an Interface Management course is organised in Stockholm, which follows on the lessons learned in the PHIS project when participants expressed an urgent need for improved interface management.

The three-day course aims to offer good practice examples about a better cooperation on medicines management between the in-patient and out-patient sectors and offers site visits to learn more about the Stockholm Model of "Wise Use for Medicines".

It will take place in Stockholm from 11 to 13 September 2012. The fee for the course is 500 Euros. The course is organised by Stockholm County Council and Karolinska Institute, supported by an international organising group.

Further information is available from the flyer and the programme attached which are also for download from the website of our WHO Collaborating Centre:
http://whocc.goeg.at

Flyer:
http://whocc.goeg.at/Downloads/News/120510_Flyer_Stockholm_Model_use_of_Drugs_pdf.pdf

Programme:
http://whocc.goeg.at/Downloads/News/Final%20Programme%20Interface%20Management%20of%20Pharmacotherapy,%20Sep%2011_13,%202012%20Stockholm.pdf

WHO EMPHASIZES IMPORTANCE OF GOOD AND HYGIENE FOR PATIENT SAFETY

On the Hand Hygiene Day on 5 May 2012, the World Health Organization (WHO) strongly emphasized the importance of good hand hygiene in regards to patient safety.

Over 15 000 health-care facilities from 156 countries participated to WHO's SAVE LIVES initiative by committing to improve patient safety through the implementation of hand hygiene best practices. This commitment will translate into 10 million health-care workers aiming to contribute to combating the often hidden but persistent hazards of health care-associated infections.

In developed countries, at least 7% of hospitalized patients will develop health care-associated infections. According to a recent WHO report, this proportion rises to 30% in intensive care units. The most common infections are urinary tract and surgical site infections, pneumonia, and infections of the bloodstream.

"*Health care-associated infection is a major burden around the world and threatens the safety and care for patients*," said Sir Liam Donaldson, WHO Patient Safety Envoy. "*I urge the health-care community to take firm and decisive action to save lives from this preventable harm.*"

According to a new WHO survey on more than 2000 healthcare facilities in 69 countries, 65% of them are showing good levels of progression with regards to hand hygiene promotion, resources and activities. However, 35% of them are still at inadequate or basic levels, and improvement is still needed in areas such as monitoring of hand hygiene practices and establishing optimal hand hygiene behaviour within a strong patient safety culture.

In this line, the WHO Patient Safety Programme is launching the Private Organizations for Patient Safety (POPS), a computer-based platform for knowledge sharing to promote compliance with WHO recommendations, share information and enhance hand hygiene product availability and accessibility in all parts of the world.

More information:
http://www.who.int/patientsafety/en/